Minnesota
Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Vision Quest Property Management

Report Number:
HL28288004 and
HL28288005

Date of Visit:
April 4, 2016

Facility Address:
5771 Meadowview Drive

Time of Visit:
11:00 a.m. - 6:00 p.m.

Date Concluded:
December 29, 2016

Facility City:
White Bear Lake

Investigator's Name and Title:
Karen Johnson, RN

State:
Minnesota

ZIP:
55110

County:
Ramsey

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when staff failed to follow the physician's medication orders. The client did not receive prescribed medication for 11 days, suffered a stroke, and was hospitalized.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of the evidence, neglect occurred. The client did not receive a prescribed anticoagulant medication for 14 days because the medication was not reordered by the licensed nursing staff, alleged perpetrator (AP), and staff members failed to report that it had not been administered. Within a week after the issue was discovered, the client had a stroke requiring hospitalization. The client died as a result of this stroke.

The client received services from the home care provider, including medication management. The client was on long term oral anticoagulant therapy due to a higher risk of stroke, secondary to atrial fibrillation and a history of prior stroke.

Ten days prior to the client's death, routine testing was conducted of the client's blood clotting rate to ensure the client's medication was at a safe and effective dose. Upon review of the clotting time results, AP noted it was abnormally low. The AP reviewed the medication administration record that indicated one milligram (mg) of warfarin was to be given daily on Tuesday, Thursday, Saturday, and Sunday, and 0.5 mg on Monday, Wednesday, and Friday. The AP discovered the client had not received any anticoagulation medication for the preceding 14 days. Pharmacy documentation confirmed the client's medications were not on a scheduled delivery, and needed to be reordered every 14 days. The medication had not been reordered by the AP during the time period prior to the 14 days of missed doses. The AP notified the client's physician and was directed to restart the medication at the previous dose and to redraw the blood work in one week. Due to the client's fragile condition, the physician did not order any additional interventions.

Four days later, the client had symptoms of stroke, emergency medical services were called, and the client was admitted to the hospital. The client was diagnosed with a stroke and treated with intravenous blood thinners. The client subsequently passed away, and the death certificate indicated the immediate cause of death was an embolic vascular accident.

The family was interviewed and stated they had not been informed of the missed anticoagulation medication, until hospital staff notified them.

The primary care physician was interviewed and indicated in his/her medical opinion, the client missing 14 days of oral anticoagulant therapy was a direct cause of the client's death.

The AP stated during an interview that the nurse who usually reordered the medications was off duty for an extended period of time. The AP was refilling the client's medications, and missed reordering the anticoagulation medication. The AP indicated that if the medication was listed on the client's medication administration record but was not in supply, the personnel who were assigned to administer medications should have reported the medication was not administered as prescribed. Several staff members had assisted the client with medications, but none had reported the medication being unavailable.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

A system was in place to ensure accurate medication administration to clients; yet, the facility failed to ensure multiple personnel followed the policy and procedure for medication administration. The AP knew the facility's policy and procedures for medication management, but failed to follow the policy and reorder medications for the client. The AP had written warnings for medication concerns in 2009, 2010, and an additional 2016 medication incident for three missed anticoagulation doses.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met

The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:
The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the

vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? (●) Yes ( ) No ( ) N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

( ) Yes (●) No ( ) N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) (●) Yes ( ) No ( ) N/A

Specify:

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: (●) Yes ( ) No ( ) N/A Specify:

Did you interview the resident(s) identified in allegation:

( ) Yes (●) No ( ) N/A Specify: Deceased

Did you interview additional residents? (●) Yes ( ) No

Total number of resident interviews:5

Interview with staff: (●) Yes ( ) No ( ) N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ( ) Yes ( ) No

Total number of staff interviews: 5

Physician Interviewed: (●) Yes ( ) No

Nurse Practitioner Interviewed: ( ) Yes (●) No

Physician Assistant Interviewed: ( ) Yes (●) No

Interview with Alleged Perpetrator(s): (●) Yes ( ) No ( ) N/A Specify:

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ( ) Yes, date subpoena was issued ( ) No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify

Observations were conducted related to:

- [x] Personal Care
- [x] Nursing Services
- [x] Infection Control
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Meals
- [x] Facility Tour
- [x] Incontinence

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: ____________________

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Osseo Police Department

Osseo City Attorney

Hennepin County Attorney

Hennepin County Medical Examiner

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H28288	A. BUILDING: ______ B. WING ______	C 01/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISION QUEST PROPERTY MANAGEMENT	**5771 MEADOWVIEW DRIVE WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On April 4, 2016, a complaint investigation was conducted to investigate complaint #HL28288005. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE